

## FINANCIAL ASSISTANCE APPLICATION

### *Charity Care & Discounted Payment Programs:*

*This application allows you to apply for both charity care and discounted payment on one form. You will receive the highest level of financial assistance based on the information provided.*

**How to Apply:**

**1. Choose Your Application Method:**

- **Online:** Apply through *MyChart* for the fastest processing.
- **Paper Application:** Download this form, fill it out, and submit it via:
  - **Email:** patientfinservices@valleychildrens.org
  - **Mail:** Send it to the hospital's financial services department (address is in the top-right corner of this form).

**2. Gather Required Documents:**

- **Proof of Income:** (choose one)
  - Most Recent Year Federal Tax Return (both applicant & co-applicant) **OR**
  - Most Recent one-month pay stubs for all employed adults in your household **OR**
  - Award Letter from Unemployment or Disability benefits

**3. Gather Optional Documents:** (not required for processing of application):

- Letter showing **approval or denial** from Medi-Cal, CCS, Medicare, or other government programs. (**not required** for discounted payment screening but is required for full charity care screening)
- Hardship Letter: An optional letter to tell us about why you are applying.

**4. Submit Your Application Online, Email or Mail:**

- Ensure all documents are included to avoid delays.
- If you need help, call **559-353-7009** or **800-956-2445** (Monday–Friday, 9am–4pm PST).

**PATIENT INFORMATION:**

<b>Patient Name:</b>	<b>Date of Birth:</b>
Guarantor/Account No:	
Does the patient have medical insurance?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have a Health Savings Account (HSA)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Has the patient applied for Medi-cal or CCS?	<input type="checkbox"/> YES <input type="checkbox"/> NO

**APPLICANT/GUARANTOR:**

<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Other _____	
Name:	Relationship to Patient:
Address:	
Cell/Phone:	Work Phone:
Employer:	Occupation/Title:



9300 Valley Children's Place-Mailstop FP103  
 Madera, CA 93636  
 Attn: Patient Financial Services

CO-APPLICANT/GUARANTOR:

<b>Name:</b>	<b>Relationship to Patient:</b>
Address:	
Cell/Phone:	Work Phone:
Employer:	Occupation/Title:

FAMILY SIZE: \_\_\_\_\_ List all dependents.

Name/Age/Relationship:	Name/Age/Relationship
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

MEDICAL EXPENSES:

It is optional to submit this information, but it could help you qualify for additional financial assistance

Other medical expenses paid by either the Applicant or Co-applicant on behalf of the patient within the last twelve (12) consecutive months.	\$
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I certify the above information is true and accurate. I understand that the information submitted may be subject to verification by Valley Children's Healthcare and reviewed by Federal and/or State Enforcement Agencies. The undersigned agree to show proof of this information along with additional information that may be requested.

\_\_\_\_\_  
 Signature of Applicant/Guarantor

\_\_\_\_\_  
 Signature of Co-Applicant/Guarantor

\_\_\_\_\_  
 Date

Valley Children's Hospital Financial Assistance may not apply to professional services provided to Valley Children's patients by physicians or other medical providers, with the exception of Emergency Room physicians.